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In the Supreme Court of the United States

OCTOBER TERM, 1997

BONNIE L. GEISSAL, BENEFICIARY AND
REPRESENTATIVE OF THE ESTATE OF JAMES W.
GEISSAL, DECEASED, PETITIONER

v.

MOORE MEDICAL CORPORATION, ET AL.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

**BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONER**

SETH P. WAXMAN
Solicitor General

LORETTA C. ARGRETT
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

JAMES A. FELDMAN
*Assistant to the Solicitor
General*

GARY R. ALLEN
TERESA E. MCLAUGHLIN
Attorneys

*Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217*

55 PR

QUESTION PRESENTED

Under 29 U.S.C. 1161(a), "continuation coverage" must be offered to employees who are participants in a group health plan and who would otherwise lose health coverage as a result of certain specified events, such as termination of employment. The employee must be provided with a specified period of time to decide whether to elect and pay for such continuation coverage. Under 29 U.S.C. 1162(2)(D)(i), such continuation coverage may end on "[t]he date on which the qualified beneficiary first becomes, after the date of the election[,] * * * covered under any other group health plan" that meets certain criteria. The question presented is:

Whether an employee who has been continuously covered under a spouse's group health plan both before and after termination of employment has "first become[], after the date of the election[,] * * * covered under any other group health plan," such that the employer may terminate (or decline to offer) continuation coverage to the employee on that basis.

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INTEREST OF THE UNITED STATES

Because of its extensive administrative and enforcement responsibilities in connection with continuation group health coverage, the United States has a substantial interest in this case. Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, 222-237 (COBRA), as amended, added parallel continuation coverage requirements to three titles of the United States Code. Group health plans of private employers are subject to the continuation coverage requirements administered by the Department of the Treasury, 26 U.S.C. 4980B, and of Labor, 29 U.S.C. 1161-1168. The Department of the Treasury enforces

compliance through an excise tax, see 26 U.S.C. 4980B, and the Department of Labor enforces compliance through civil actions, see 29 U.S.C. 1132(a). Group health plans of state and local governments are subject to the continuation coverage requirements administered by the Department of Health and Human Services. See 42 U.S.C. 300bb-1 through 300bb-8.

STATUTORY PROVISIONS INVOLVED

The text of 29 U.S.C. 1161-1167 is reproduced in an appendix to this brief.

STATEMENT

1. Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82, 222-237, as amended, requires private employers¹ and state and local governments sponsoring group health plans (other than churches and certain small employers) to afford employees and their family members the opportunity to elect to continue health coverage temporarily at group rates in certain circumstances in which coverage might otherwise terminate. This case concerns the availability of such coverage to an employee who is already covered by another plan.

The ability to elect continuation coverage is triggered by the occurrence of a "qualifying event," which is one of a number of enumerated events that would otherwise cause a "qualified beneficiary" to

¹ COBRA generally imposes requirements on plan sponsors (usually, employers) and on the plans themselves. References in this brief to the employer should be understood to refer to other plan sponsors and the plans themselves, where appropriate.

lose coverage. See 26 U.S.C. 4980B(f)(1); 29 U.S.C. 1161(a); 42 U.S.C. 300bb-1(a). The enumerated events include the employee's death, divorce or separation, termination of employment (other than for gross misconduct), or reduction of hours of employment. See 26 U.S.C. 4980B(f)(3); 29 U.S.C. 1163; 42 U.S.C. 300bb-3. A "qualified beneficiary" includes the employee (in case of his termination of employment or reduction in hours), the employee's spouse, and dependent children. See 26 U.S.C. 4980B(g)(1); 29 U.S.C. 1167(3); 42 U.S.C. 300bb-8(3). Although the plan is permitted to require the payment of a premium for COBRA continuation coverage, it generally may charge the qualified beneficiary no more than 102 percent of the "applicable premium," which is the plan's cost of coverage for similarly situated beneficiaries who have not undergone a qualifying event; that cost is determined without regard to whether it would ordinarily be paid by the employee or the employer. See 26 U.S.C. 4980B(f)(2)(C) and (4)(A); 29 U.S.C. 1162(3), 1164(1); 42 U.S.C. 300bb-2(3), 300bb-4(1). The continuation coverage is required to be identical to that enjoyed by similarly situated beneficiaries who have not undergone a qualifying event. See 26 U.S.C. 4980B(f)(2)(A); 29 U.S.C. 1162(1); 42 U.S.C. 300bb-2(1).

If a qualifying event occurs, the plan administrator is to notify the qualified beneficiary of his right to elect continuation coverage. See 26 U.S.C. 4980B(f)(6); 29 U.S.C. 1166; 42 U.S.C. 300bb-6. The election period begins not later than the date on which coverage would otherwise terminate under the plan by reason of a qualifying event; it must be of at least 60 days' duration, and it may not end earlier than 60 days from the later of the qualifying event or the date the qualified beneficiary is notified of

the right to continuation coverage. 26 U.S.C. 4980B(f)(5)(A); 29 U.S.C. 1165(1); 42 U.S.C. 300bb-5(1); see *Branch v. G. Bernd Co.*, 955 F.2d 1574 (11th Cir. 1992). Thus, when the qualifying event is termination of employment, the election period must extend at least 60 days from the date of termination.

The issue in this case involves the provisions governing the "period of coverage." 26 U.S.C. 4980B(f)(2)(B); 29 U.S.C. 1162(2); 42 U.S.C. 300bb-2(2). After providing that "[t]he coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following," the statute sets forth the maximum required period of coverage, generally 18 months from the date of the qualifying event in the case of termination of employment. 26 U.S.C. 4980B(f)(2)(B)(i)(I); 29 U.S.C. 1162(2)(A)(i); 42 U.S.C. 300bb-2(A)(i). Several circumstances that permit cessation of continuation coverage before the expiration of the relevant maximum period are then set forth, including the employer's ceasing to provide a group health plan to any employee and the qualified beneficiary's failure to make timely payment of any required premium. 26 U.S.C. 4980B(f)(2)(B)(ii) and (iii); 29 U.S.C. 1162(2)(B) and (C); 42 U.S.C. 300bb-2(2)(B) and (C). The provision in issue here permits the employer to cease coverage on

The date on which the qualified beneficiary first becomes, after the date of the election—

(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary.

29 U.S.C. 1162(2)(D); see also 26 U.S.C. 4980B(f)(2)(B)(iv); 42 U.S.C. 300bb-2(2)(D).² As originally enacted, this provision did not explicitly preclude the employer from terminating coverage merely because the other group health plan excluded or limited benefits for pre-existing conditions.³ See note 14, *infra*. In 1989,

² The statute is reproduced as applicable in this case. Section 1162(2)(D)(i) and other provisions were amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, §§ 101, 102, 401, 421, 110 Stat. 1939-1943, 1955-1959, 2073-2077, 2084-2089. See App., *infra*, 1a-16a. That Act generally limited exclusion periods for preexisting conditions under group health plans to 12 months and reduced such periods by periods of "creditable coverage," including COBRA coverage and other coverage under a group health plan. See 26 U.S.C. 9801(a)(2), (3), (c)(1)(A) and (e)(1) (to be codified); 29 U.S.C. 1181(a)(2), (3), (c)(1)(A) and (e)(1) (to be codified); 42 U.S.C. 300gg(a)(2), (3), (c)(1)(A) and (e)(1) (to be codified). At the same time, Congress amended the pre-existing condition exclusion provisions of 26 U.S.C. 4980B(f)(2)(B)(iv)(I), 29 U.S.C. 1162(2)(D)(i) and 42 U.S.C. 300bb-2(2)(D)(i) to reflect that continuation coverage may be cut off where a plan's pre-existing condition exclusion does not apply to, or is satisfied by, the beneficiary by reason of HIPAA. HIPAA § 421, 110 Stat. 2084-2089.

³ As originally enacted, COBRA's provisions amending the Internal Revenue Code took the form of a mechanism in 26 U.S.C. 162(i) for denying a business expense deduction for plan expenses and in 26 U.S.C. 106(b) for denying the exclusion from gross income for contributions on behalf of highly compensated individuals where plans did not meet the requirements of 26 U.S.C. 162(k). See COBRA § 10001(a) and (b), 100 Stat. 222-223. In 1988, Congress, believing that the sanctions for noncompliance should take certain ameliorative factors into account, see H.R. Rep. No. 795, 100th Cong., 2d Sess. 485-486 (1988), repealed those sanctions, and created instead the excise tax found in 26 U.S.C. 4980B. See Technical and Miscellaneous

however, Congress amended the relevant statutory sections to provide, as set forth above, that the employer may terminate coverage only if the other group health plan contains no exclusion or limitation with respect to a pre-existing condition of the beneficiary. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6701, 103 Stat. 2294.

2. Petitioner is the widow, and the personal representative of the estate, of James W. Geissal (Geissal), who died after instituting this suit. Pet. App. A1-A2, A20. Respondent Moore Medical Corp. (Moore) is Geissal's former employer and the sponsor of respondent Group Benefit Plan of Moore Medical Corp. (the Moore plan), a group health plan established for the benefit of Moore's employees. *Id.* at A2, A21-A22. Respondent Herbert Walker is the plan administrator. *Id.* at A20.

While employed by Moore, Geissal was a participant in the Moore plan. Pet. App. A2, A21. At the same time, Geissal was also covered as a dependent eligible for health benefits under a plan maintained by petitioner's employer, Trans World Airlines (TWA), through a policy issued by Aetna Life Insurance Company (Aetna). *Id.* at A2, A22. The Moore plan had an annual deductible of \$150 and provided for a lifetime maximum amount of benefits, but only as to payments it made. The TWA plan had an annual deductible of \$500 per person and also provided a lifetime maximum amount of benefits it would pay. *Id.* at A22.

On July 16, 1993, after working for Moore for more than seven years, Geissal was fired. He was then age 62 and ill with cancer. Pet. App. A2, A21. Geissal

Revenue Act of 1988, Pub. L. No. 100-647, § 3011, 102 Stat. 3616-3624.

requested and received a letter from Moore under Missouri Ann. Stat. § 290.140 (West 1993), "truly stating for what cause, if any, [he] was discharged." Pet. App. A2 & n.3, A23. He considered consulting an attorney to investigate what rights and claims he might have against Moore because he felt his employment was unfairly terminated, but he decided not to do so; his main concern was that he have full and adequate health coverage. *Id.* at A3, A23. Geissal received a notice of his right under COBRA to continue group health coverage under the Moore plan. *Id.* at A22. Moore's representatives encouraged him to make the COBRA election, which did much to assuage his concerns about the effect of his discharge. At about that time, the Moore plan or its reinsurer was making large payments for medical care provided to Geissal prior to his termination. *Id.* at A23. Geissal made a timely election to continue receiving group health coverage under the Moore plan. In accordance with that election, he began making premium payments, and Moore initially accepted those payments. *Id.* at A3, A22.

Approximately six months after his termination, respondents informed Geissal that they had determined that he was not entitled to continuation coverage under the Moore plan because at the time of his termination he was already covered under the TWA plan on the basis of his wife's employment. Geissal was told that his premiums would be returned and that the Moore plan would not pay those persons who had provided him with care, but would instead return the bills to them unpaid. Pet. App. A3, A22. Although the record is not entirely clear on this point, it does not appear that respondents made any distinction in this regard between premiums paid (and bills

incurred) for the period prior to Geissal's election and premiums paid (and bills incurred) for the period following that election.

3. Geissal then brought this suit in the United States District Court for the Eastern District of Missouri, alleging that respondents had violated COBRA by failing to accord him continuation coverage. He further argued that respondents were equitably estopped from denying him such coverage, that respondents had waived any right to contest his coverage by accepting his premium payments, and that he had not received certain plan documents to which he was entitled. Pet. App. A21.

Geissal moved for partial summary judgment on the issue of whether he was entitled to elect COBRA continuation coverage. Pet. App. A23. Invoking 29 U.S.C. 1162(2)(D)(i), Geissal argued that he was entitled to COBRA continuation coverage until he "first becomes, after the date of the election[,] * * * covered under any other group health plan." He asserted that, since he had "first become[]" a beneficiary of the TWA plan *before* making his election, rather than "after" doing so, he was entitled to continuation coverage under the Moore plan notwithstanding his coverage under the TWA plan. Pet. App. A27. Respondents contended that the fact that Geissal was covered under the TWA plan when his employment was terminated served to disqualify him from COBRA continuation coverage.

A magistrate judge, sitting by consent under 28 U.S.C. 636(c), denied Geissal's motion and held, *sua sponte*, that respondents were entitled to partial summary judgment. Pet. App. A20-A36. The magistrate judge ruled that pre-existing dual coverage renders a person ineligible to elect COBRA continuation

coverage. *Id.* at A30. Geissal argued that a "significant gap" sufficient to require continuation coverage under the Moore plan existed⁴ because the TWA plan had a higher deductible than the Moore plan, because coverage for some kinds of care under the Moore plan was somewhat more extensive than under the TWA plan, or because Geissal had stood to enjoy the benefit of two potential lifetime maximums (since each plan took into account only its own expenditures in computing the ceiling); the magistrate judge rejected those arguments. *Id.* at A32. The magistrate judge also granted respondents partial summary judgment, *sua sponte*, on the equitable estoppel issue. Pet. App. A35.

4. The court of appeals affirmed. Pet. App. A1-A18. In its view, "Congress was fundamentally interested in making affordable health care temporarily available to those who otherwise would find themselves 'without any health insurance coverage.'" *Id.* at A10-A11 (quoting H.R. Rep. No. 241, 99th Cong. 1st Sess. Pt. 1, at 44 (1985)). The court therefore read 29 U.S.C. 1162(2)(D)(i) as authorizing the termination of continuation coverage "on the day that a former employee becomes a beneficiary under 'any other group health plan,'" Pet. App. A11 (quoting 29 U.S.C. 1162(2)(D)(i)), and it concluded that "it is largely irrelevant under the Act whether the employee obtained that coverage before or after his COBRA

⁴ As we explain below (see pp. 25-30, *infra*), some courts that have construed the statute to allow termination of continuation coverage where the beneficiary is covered under a pre-existing plan have limited the employer's right of termination to situations in which there is no "significant gap" in coverage between the continuation plan and the pre-existing other plan.

rights are activated," *ibid.* (footnote omitted). According to the court, the language in 29 U.S.C. 1162(2)(D)(i) allowing continuation coverage to be terminated when the beneficiary "first becomes, after the date of the election," covered under any other group health plan * * * was not meant to absolutely insulate from the exception persons who enjoy pre-existing insurance, but was merely intended to pinpoint the day on which the presence of that coverage becomes pertinent." Pet. App. A12 (citation omitted). In the court's view, "the first time, *after the date of election*, that James Geissal became covered under his wife's plan with TWA was the very moment after the election date." *Ibid.* The court of appeals concluded that the fact that Geissal was covered under the TWA plan, as of that date, sufficed under 29 U.S.C. 1162(2)(D)(i) to allow respondents to cancel Geissal's continuation coverage, unless there was a "significant gap" between the coverage provided under the Moore plan and that provided under the TWA plan. Pet. App. A14.

The court of appeals then rejected the argument that there was a "significant gap" between the coverage of the two plans. The court stated that the gap should be measured "by comparing the policies' provisions in light of information available to the employer on the day of the COBRA election." Pet. App. A14. The court observed that the record did not permit it to conclude that the TWA plan offered "appreciably fewer benefits" or excluded claims for any pre-existing condition of Geissal's, and that the two plans, "while not completely identical," each provided "comprehensive medical benefits." *Ibid.* It termed the two differences identified by petitioner, *i.e.*, the differences in the annual deductible and

the separate lifetime maximums, to be "rather insubstantial dissimilarities [that] fall far short of the quantum of proof necessary to demonstrate a significant gap in coverage." *Id.* at A15.⁵ The court of appeals also agreed with the magistrate judge that petitioner's equitable estoppel claim failed for lack of proof of detrimental reliance. *Id.* at A17.

SUMMARY OF ARGUMENT

Under COBRA, an employer may terminate continuation coverage on "[t]he date on which the qualified beneficiary first becomes, after the date of the election[,] * * * covered under any other group health plan." That language refers to a time, after the beneficiary's election to purchase COBRA continuation coverage, when the beneficiary becomes covered, for the first time, by another plan. Thus, the plain language prohibits an employer from refusing

⁵ Although the court of appeals focused on the existence of other coverage under the TWA plan immediately following the date of election as a basis for allowing respondents to cancel such coverage, it is not entirely clear from its opinion whether, in its view, respondents were permitted to cancel the continuation coverage as of the date of termination of Geissal's employment or only as of the day after the date of his election. The court of appeals did, however, affirm the magistrate judge's ruling, which apparently was based on the proposition that Geissal was ineligible for COBRA continuation coverage for any period at all. See Pet. App. A26 ("The cardinal issue between the present parties is whether James Geissal's pre-existing (Aetna) insurance coverage made him ineligible for continuation coverage with the Fund upon his termination."). We are unable to ascertain from the record here whether a holding that Geissal was entitled to such benefits for the period between the date of his firing and the date he elected continuation coverage would have entitled petitioner to any of the requested relief in this case.

to provide continuation coverage (or terminating it immediately after it is elected) on the ground that the beneficiary has been covered all along under a spouse's plan.

That conclusion is supported by the detailed, express statutory requirements that the employer must notify the beneficiary of the right to continuation coverage and give the beneficiary up to 60 days to decide whether to elect it. Congress would not have created a scheme whereby an employer must engage in a charade of that sort, knowing all along that as soon as an employee in Geissal's position elected the continuation coverage, the employer could terminate it altogether. Indeed, the sooner the employer could entice the beneficiary in that situation to elect the continuation coverage, the sooner the employer could cancel it.

An examination of Congress's purposes in enacting the COBRA continuation coverage provisions does not alter the conclusion that it is only the beneficiary's acquisition of new coverage—not maintenance of pre-existing coverage—that permits the employer to terminate continuation coverage. As attested by a number of provisions of the Act, Congress's purpose was to preserve the beneficiary's health care status quo. That purpose is served by precluding employers from terminating coverage merely because a beneficiary has all along been covered under another group health plan, regardless of the scope or adequacy of that plan. It is the beneficiary, after all, who is in the best position to decide whether his COBRA premium is warranted or would result in double coverage that is not worth the expense. Beneficiaries should not be deprived of the opportunity to maintain their prior

level of coverage and be forced to accept lesser levels of coverage they consider inadequate.

Finally, the interpretation adopted by the court of appeals and the other courts of appeals with which it agrees would immerse plan administrators in costly, difficult, and highly litigious issues. That interpretation would require an employer to provide continuation coverage if, presumably at the time of election, there is a "significant gap" between the continuation coverage offered by the employer's plan and the beneficiary's coverage under the other, pre-existing health plan. The inquiry into whether there is a "significant gap," however, would be an indeterminate one. If it required an assessment of the beneficiary's future medical needs and the extent to which those needs would in fact be covered under the new plan, then a plan administrator could not confidently make the required determination at the time of election. And even if the "significant gap" inquiry merely required an assessment of the beneficiary's current medical conditions and the coverage of those conditions under the pre-existing plan, it still would require the plan administrator to know details about the beneficiary's medical condition and the new plan that are unlikely to be readily available at the time of election. By contrast, under the construction we advocate, the plan administrator's task is much simpler: continuation coverage must be provided until the employee joins a new group health plan satisfying the statutory "no exclusion for preexisting condition" qualification after the date of election or until some other terminating event occurs. No inquiry into whether there is a "significant gap" in coverage between the old plan and the new plan need be undertaken.

ARGUMENT

THE RIGHT TO CONTINUATION COVERAGE UNDER COBRA CEASES BY REASON OF A QUALIFIED BENEFICIARY'S BECOMING COVERED BY ANOTHER GROUP HEALTH PLAN ONLY WHERE HE "FIRST BECOMES" COVERED BY THAT PLAN "AFTER THE DATE OF THE ELECTION"

This case presents the question of which of two competing interpretations of COBRA's continuation coverage provisions is correct. Two courts of appeals—the Seventh and Tenth Circuits—have held that an employer may not terminate (or refuse to offer) COBRA continuation coverage under its plan merely because a terminated employee had pre-existing coverage under another group health plan.⁶ The court below and two other courts of appeals—the Eleventh and Fifth Circuits—have held that an employer may do so.⁷ Although the Internal Revenue Service published a proposed regulation in 1987 that essentially endorsed the latter view, that regulation was never made final, and the IRS has now determined, upon further consideration of the matter, that the better interpretation is the one that does not allow a termination of continuation coverage on

⁶ See *Lutheran Hosp., Inc. v. Business Men's Assurance Co.*, 51 F.3d 1308 (7th Cir. 1995); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989), cert. denied, 494 U.S. 1082 (1990).

⁷ See *National Companies Health Benefit Plan v. St. Joseph's Hosp., Inc.*, 929 F.2d 1558 (11th Cir. 1991); *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990).

account of other, pre-existing group health coverage.⁸ For the reasons given below, we submit that pre-

⁸ The proposed regulations state that a qualified beneficiary's eligibility for continuation coverage ends on "the first date after the date of the election upon which the qualified beneficiary is covered * * * under any other group health plan that is not maintained by the employer, even if that other coverage is less valuable to the qualified beneficiary than COBRA continuation coverage." Prop. Treas. Reg. § 1.162-26, Q&A38-(d), 52 Fed. Reg. 22,730 (1987). On March 4, 1998, the Internal Revenue Service is releasing Announcement 98-22, noting that "after further consideration of the issue, * * * Treasury and the Internal Revenue Service now believe that the better interpretation of the statute is that a plan is not permitted to cease making COBRA coverage available merely because of other coverage (or entitlement to Medicare benefits) that began before the date of the election for COBRA coverage." *Id.* at 4 (to be published in Internal Revenue Bulletin 1998-12 (Mar. 23, 1998)). (We are lodging a copy of this announcement with the Court and serving it upon the parties to this case.) The reference to Medicare benefits is a reference to a provision that is parallel to the one at issue in this case. Under 29 U.S.C. 1162(2)(D)(ii), an employer may terminate continuation coverage on "[t]he date on which the qualified beneficiary first becomes, after the date of election[,] * * * entitled to benefits under [Medicare]."

When it published the proposed regulations, the IRS announced that, until final regulations are published, the tax sanctions for noncompliance will not apply if employers and group health plans operate in good faith compliance with a reasonable interpretation of the statutory requirements. 52 Fed. Reg. at 22,716-22,717; see also Rev. Rul. 96-8, 1996-1 C.B. 286. Compliance with the terms of the proposed regulations constitutes *per se* good faith compliance, but a failure to comply with the proposed regulations is not necessarily treated as a lack of good faith compliance, and all the relevant facts and circumstances will be taken into account. 52 Fed. Reg. at 22,717. In Announcement 98-22, the IRS is providing, for purposes of tax sanctions, for continued reliance on the proposed

existing coverage under another group health plan is not a sufficient basis for an employer to terminate or refuse to offer COBRA continuation coverage to an otherwise eligible beneficiary.

A. Under The Plain Language Of The Act, An Employer May Cease Continuation Coverage Only Upon The Beneficiary's Accession To New Coverage After The Election Of Continuation Coverage

1. The "starting point in every case involving construction of a statute is the language itself." *Greyhound Corp. v. Mt. Hood Stages, Inc.*, 437 U.S. 322, 330 (1978) (internal quotation marks omitted). The words of statutes "should be interpreted where possible in their ordinary, everyday senses." *Malat v. Riddell*, 383 U.S. 569, 571 (1966) (quoting *Crane v. Commissioner*, 331 U.S. 1, 6 (1947)).

Under 29 U.S.C. 1162(2)(D)(i), the right to continuation coverage ends on "[t]he date on which the qualified beneficiary first becomes, after the date of the election[,] * * * covered under any other group health plan." One of the dictionary definitions of the adverb "first" is "for the first time." *Webster's Third New International Dictionary of the English Language* 856 (1986). To "become" is defined to include "to pass from a previous state or condition and come to be: grow or change into being through taking on a new character or characteristic." *Id.* at 195. It is also defined as "to come to be—used as an auxiliary in passive constructions." *Ibid.* Thus, the statutory phrase referring to the time when the beneficiary "first becomes, after the date of the election[,] * * * covered" under another plan refers to a time when the

regulation's treatment of the question presented here, pending this Court's decision in this case.

beneficiary for the first time after the date of election comes to be covered by a new plan. If the beneficiary was already covered by another plan, he cannot first become covered by it after the date of election. Unless the words "first," "becomes," and "after" are disregarded, the phrase cannot refer to a date, after the date of election, when the beneficiary merely continues to be covered by a pre-existing plan.⁹ As the Seventh Circuit held in *Lutheran Hospital, Inc. v. Business Men's Assurance Co.*, 51 F.3d 1308, 1312 (1995), "[t]he statute clearly provides that the employee's right to continuation coverage terminates only when he or she *first* becomes, *after* the election date, *covered* by any other group health plan." See also *Oakley v. City of Longmont*, 890 F.2d 1128, 1132 (10th Cir. 1989) ("the plain meaning of this subsection cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation coverage"), cert. denied, 494 U.S. 1082 (1990).

The court of appeals held (Pet. App. A12) that this provision was "merely intended to pinpoint the day on which the presence of that coverage becomes pertinent." See also *National Companies Health*

⁹ The situation is parallel to that addressed by the Court in *Shalala v. Whitecotton*, 514 U.S. 268 (1995). In that case, the Court construed a statute in which a claimant for benefits had to prove that "the first symptom or manifestation of the onset" of an illness occurred "after vaccine administration." *Id.* at 274 (internal quotation marks omitted). The Court rejected the claim of a person whose first symptom or manifestation occurred before the vaccination, reasoning that "[i]f a symptom or manifestation * * * has occurred *before* a claimant's vaccination, a symptom or manifestation *after* the vaccination cannot be the first, or signal the injury's onset." *Ibid.* (emphasis added).

Benefit Plan v. St. Joseph's Hosp., Inc., 929 F.2d 1558, 1570 (11th Cir. 1991). The provision would have been subject to that construction if Congress had written the statute to provide for coverage until the "date, after the date of election, on which the beneficiary is covered" by another group health plan. But Congress did not write the statute in that way, and the court of appeals' construction is accordingly mistaken.

2. Requiring an employer to provide continuation coverage until the beneficiary first becomes covered, after the date of election, by a new health plan is supported by other aspects of the statutory scheme for COBRA coverage. Under any possible reading, the statute mandates that continuation coverage be made available "beginning on the date of the qualifying event," such as termination of employment. 29 U.S.C. 1162(2). It also mandates, under any possible reading, that such coverage continue at least until the date of election, since, under 29 U.S.C. 1162(2)(D) (i), the existence of coverage under another plan is only of significance "after" that date. Thus, under any possible reading of the statute, the employer must provide continuation coverage at least until the date of election.¹⁰

Before the date of election, the statute imposes detailed notice requirements. The employer must generally give the plan administrator notice of the termination of the employee within 30 days of its occurrence. 29 U.S.C. 1166(a)(2). Within 14 days

¹⁰ It is not clear that the court of appeals and some other courts with which it agrees have realized that COBRA coverage is mandatory at least until the date of election. See Pet. App. A10 (quoting statement in *National Companies*, 929 F.2d at 1558, that "[i]n effect, such an employee [with other pre-existing coverage] is ineligible for continuation coverage").

of receiving such notice, see 29 U.S.C. 1166(c), "the administrator shall notify * * * any qualified beneficiary * * * of such beneficiary's rights under this subsection," 29 U.S.C. 1166(a)(4). The beneficiary then must be given at least 60 days to decide whether to elect continuation coverage. 29 U.S.C. 1165(1)(C)(ii). If the beneficiary elects continuation coverage, the coverage generally is retroactive to the date of the qualifying event. 29 U.S.C. 1162(2).

Under the interpretation given the statute by the court of appeals, this elaborate statutory scheme would be anomalous in cases like this one, where the beneficiary had pre-existing coverage under a spouse's plan. Under that interpretation, Congress would have required employers to follow meticulous requirements in notifying terminated employees of their rights to continuation coverage and to give terminated employees a 60-day period to consider whether to accept (and pay for) such coverage; yet, as soon as an employee elected such coverage, the employer would be entitled to cut it off immediately. Moreover, the earlier the employee decided to exercise the option to elect coverage, the less coverage the employee would get. An employee who believed it to be to his benefit to elect continuation coverage immediately would sadly find that the effect of that election was to eliminate the 60 days of coverage to which he was entitled, even under the most restrictive reading of the statute. It should not readily be assumed that Congress intended to institute that kind of apparently pointless ritual.

Under our interpretation of the statute, by contrast, the entire scheme makes sense. The employee whose employment has been terminated receives notice of eligibility for continuation coverage and

has 60 days to decide whether to elect to receive it. During that period, the employee may decide whether, taking into account the existence of pre-existing coverage and other considerations, the cost of continuation coverage is warranted. If not, the employee decides not to elect continuation coverage, and the employer need not provide it. If the employee elects to purchase the continuation coverage, however, the employer must honor that election—at least until the employee becomes newly covered under some other group health plan or some other terminating event under 29 U.S.C. 1162(2) occurs. Thus, the election period serves its purpose of ensuring that affected beneficiaries have a reasonable time to sort through their economic and medical circumstances to determine whether it is worth their while to pay for continuation coverage for periods extending not only up to the date of the election, but for such time until there is a material change in their health benefit coverage or until the maximum required period expires.

B. The Purposes Of The Statute Support COBRA Coverage For Beneficiaries With Pre-Existing Coverage

1. The court of appeals indicated that its construction of the statute was dictated by what it believed to be the underlying purpose of COBRA continuation coverage. The court read a statement in the House Report on the COBRA bill to indicate that the legislation was intended to make coverage temporarily available “to those who would otherwise find themselves ‘without any health insurance coverage.’” Pet. App. A10-A11 (quoting H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 44 (1985)). The

court reasoned that, if Congress was concerned only with making coverage available to those who had no health coverage, Congress would not have intended that those who had additional pre-existing coverage should be able to take advantage of the statute’s benefits.

The passage on which the court of appeals relied, however, was contained in a sentence in the introductory paragraph of the pertinent section of the House Report, which described the Committee’s concern with the state of health insurance coverage in the United States generally.¹¹ It did not purport to describe the scope of the continuation coverage provisions. Nor did the Report’s subsequent description of the continuation coverage provisions itself suggest the sort of limited purpose the court of appeals posited.¹² The court of appeals therefore erred in reading a limitation into the continuation coverage provisions on the basis of a general observation in the committee report. See *Oncale v. Sundowner Offshore Servs., Inc.*, No. 96-568 (Mar. 4, 1998), slip op. 3 (“[I]t is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.”); *Brogan v. United States*,

¹¹ The sentence, in its entirety, reads: “The Committee is concerned with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation’s hospitals to provide care to those who cannot afford to pay.” H.R. Rep. No. 241, *supra*, Pt. 1, at 44.

¹² It simply stated that a “continuation option would be available” to the specified groups, and that thereafter “[c]overage would be cancelled” if, *inter alia*, the qualified beneficiary “became covered under another group policy or medicare.” H.R. Rep. No. 241, *supra*, Pt. 1, at 44-45.

118 S. Ct. 805, 809 (1998) (“[I]t is not, and cannot be, [this Court’s] practice to restrict the unqualified language of a statute to the particular evil that Congress was trying to remedy—even assuming that it is possible to identify that evil from something other than the text of the statute itself.”).

Indeed, in other respects, the circumstances surrounding the enactment of the continuation coverage provisions in 1986 substantially undermine the court of appeals’ reliance on the passage in the House Report as support for its view that the mere fact that an employee has pre-existing coverage under his or her spouse’s group plan was intended to render the employee ineligible for continuation coverage. Most significant is the text of the provisions Congress enacted.

As originally enacted in COBRA, the continuation coverage provisions permitted termination on “[t]he date on which the qualified beneficiary first becomes, after the date of the election[,] * * * a covered employee under any other group health plan,” and it also permitted termination, “[i]n the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, [on] the date on which the beneficiary remarries and becomes covered under a group health plan.” COBRA §§ 10001(c), 10002(a), 100 Stat. 224, 228. Under that formulation, an employer could not terminate coverage based on pre-existing coverage under a spouse’s health plan, because the statute permitted termination only where, “after the date of election,” the beneficiary “becomes * * * a covered employee” under any other group health plan.

The Tax Reform Act of 1986, Pub. L. No. 99-514, § 1895(d), 100 Stat. 2938, deleted the references to

reemployment and remarriage, consolidated the two provisions, and adopted the current statutory language defining the event in question as the qualified beneficiary’s “first becom[ing]” covered “under any other group health plan (as an employee or otherwise).” The change no doubt broadened the varieties of new coverage that would permit an employer to terminate continuation coverage. See *National Companies*, 929 F.2d at 1570-1571. For example, an employer could not originally terminate a beneficiary who enrolled in a spouse’s plan but who had not remarried, or a minor child beneficiary who obtained new coverage as a result of the remarriage of a parent; under the amended statute, the employer may terminate continuation coverage in each of those circumstances. There is no indication, however, that Congress intended in that amendment to alter the original understanding that pre-existing coverage under another plan would not provide a basis for termination. Indeed, had it wanted to do that, it could easily have altered the operative “first becomes * * * after” language that remained from the statute as originally enacted.

2. We of course agree that in enacting and amending the COBRA provisions, Congress intended at least to ensure that temporary health coverage would be available for those who would otherwise find themselves without any coverage at all. Under our interpretation, as under the interpretation adopted by the court below, the statute Congress wrote accomplishes that purpose. In our view, however, the statute serves a somewhat broader purpose as well. By distinguishing between pre-existing and after-acquired group health coverage, the statute “facilitates the preservation of the beneficiary’s health care

status quo." *Lutheran Hospital*, 51 F.3d at 1312. The beneficiary is assured that, so long as he is willing to pay for continuation coverage, his health care benefits will not be altered during the temporary period (usually 18 months, if COBRA coverage is triggered by termination of employment, see 29 U.S.C. 1162(2)(A)(i)) while he seeks new employment or otherwise makes arrangements for future health care needs.

The purpose to ensure that a beneficiary willing to pay for it may maintain the health care status quo is evident in other provisions of the statute. For example, the statute does not merely require the employer to provide some minimal level of health coverage. Instead, it requires the continuation coverage to be "identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred." 29 U.S.C. 1162(1). That requirement supports the conclusion that Congress structured the statute not merely to provide some measure of health coverage to individuals who would otherwise have none at all, but more generally to permit covered individuals to maintain the health care status quo. Under our interpretation, that purpose is fully achieved.

That purpose appears in another feature of the statutory scheme as well. Had Congress intended only to ensure that covered employees had access to *some* health care coverage, it easily could have permitted employers to cease COBRA coverage as soon as a beneficiary "first becomes eligible" for coverage under another group health plan. Such individuals would be guaranteed access to some health care coverage, and—under the court of appeals'

construction—the statutory purpose would not support any additional protection. But Congress wrote the statute to permit termination of COBRA coverage based on a beneficiary's actual coverage—not mere eligibility—under another group health plan. See 29 U.S.C. 1162(2)(D)(i) (permitting termination of coverage when a beneficiary "first becomes * * * covered" under another plan) (emphasis added). Congress thereby preserved a choice for the beneficiary who becomes eligible for another group health plan as a result of a new job or other change. The beneficiary may choose to join the new plan and thereby lose the right to COBRA coverage, or the beneficiary may choose to continue COBRA coverage for the maximum continuation period or until some other terminating event occurs. That option is fully consistent with our view that Congress structured the statute to give beneficiaries the right to continue the health care status quo, if they so desired, for the full COBRA coverage period.

C. The Court Of Appeals' Construction Of The Statute Would Create A Scheme That Would Be Difficult To Administer And That Would Invite Litigation

Each of the courts of appeals that has construed the statute to permit an employer to terminate coverage for beneficiaries who were covered under other pre-existing group health plans has qualified its holding to provide that an employer may not terminate coverage if there is a "significant gap" in coverage between that offered under the employer's health plan and that available under the other, pre-existing plan.¹³

¹³ See, e.g., Pet. App. A12 (respondent could terminate coverage "unless there was 'a significant gap between the coverage afforded under [Moore's] plan and [Geissal's] pre-

The term "significant gap" is apparently borrowed from language in the House Report on the 1989 amendment, which addressed quite another issue—the need to enact an exception to the continuation-coverage cutoff date where the other plan under which the beneficiary becomes covered excludes or limits benefits for a pre-existing condition of the beneficiary. See Pet. App. A12 n.10 (quoting H.R. Rep. No. 247, 101st Cong., 1st Sess., at 1452-1453 (1989)). It was *that* gap in coverage to which the phrase in the 1989 House Report was specifically directed. See *id.* at 1453. Congress responded to that problem by specifying that the duty to provide continuation coverage does not terminate even when the beneficiary *does* first become covered under another plan after the date of election, if the other plan contains an exclusion or limitation for pre-existing conditions. Nothing in that decision by Congress in 1989 purports to allow an employer—by invoking a non-textual "significant gap" test—to withhold continuation coverage if the employee *does not* first become covered under a new plan after the date of election.

An amorphous "significant gap" standard, moreover, would be difficult for plan administrators to understand and apply, and would likely lead to extensive litigation. Because our interpretation of the

existing plan'"); *National Companies*, 929 F.2d at 1571 ("If there is a significant gap between the coverage afforded under his employer's plan and his preexisting plan, an employee will be eligible for continuation coverage."); *Brock*, 904 F.2d at 297 (noting "Congress's concern that group health plan participants and their dependents not be placed in a situation in which they suffer a gap in the character of coverage as the result of a 'qualifying event' such as termination of employment").

statute eliminates the need to conduct such an inquiry, it makes it substantially easier to achieve Congress's purpose of having a simple, easily administrable system for ensuring continuation health coverage.¹⁴

There is a decided lack of unanimity regarding the proper time frame for making the "significant gap"

¹⁴ Notably, some cases in which courts used the "significant gap" approach of comparing the respective plans' benefits in determining whether the extent of the other plan's coverage merited the loss of continuation coverage dealt with situations predating the effective date of the 1989 amendment that created an exception to the coverage cutoff where the other plan limits benefits for a pre-existing condition. Some courts in such cases found that there was a "significant gap" justifying continuation coverage where the new coverage contained an exclusion for a pre-existing condition. See *Teweleit v. Hartford Life and Accident Ins. Co.*, 43 F.3d 1005, 1010 & n.6 (5th Cir. 1995) (holding that the 1989 amendment did not effect a substantive change in the law, but did no more than clarify the original provision); *Conery v. Bath Associates*, 803 F. Supp. 1388, 1403 (N.D. Ind. 1992) (same); contra, *Martin v. Prudential Ins. Co.*, 776 F. Supp. 1172 (S.D. Miss. 1991). Now that the statute makes an express exception to the loss of continuation coverage where the other plan does not cover a pre-existing condition, it is clear that the most compelling reason for extending continuation coverage on a non-textual "significant gap" theory no longer exists. The fact that one plan is less generous than another simply is not a sufficient basis on which to preserve continuation coverage once the beneficiary actually becomes covered under the new plan. See *Liberty Life Assurance Co. v. Toys "R" Us, Inc.*, 901 F. Supp. 556, 564 (E.D.N.Y. 1995); *Daniel v. Master Health Plan, Inc.*, 864 F. Supp. 1399, 1406 (S.D. Ga. 1994). But whatever the merit of the decisions extending coverage under the pre-1989 version of the statute on that basis, they furnish no basis for eliminating continuation coverage that is required by the terms of the current statute.

comparison between the continuation coverage and the pre-existing coverage. Some courts have compared the results after the beneficiary has incurred medical expenses. See *National Companies*, 929 F.2d at 1571; *McGee v. Funderberg*, 17 F.3d 1122, 1126 (8th Cir. 1994). Other courts, including the court of appeals in this case (see Pet. App. A14), have called for comparing the coverage under the two plans at the time of the election. See *Lutheran Hosp. v. Business Men's Assurance Co.*, 845 F. Supp. 1275, 1289 (N.D. Ind. 1994), rev'd on other grounds, 51 F.3d 1308 (7th Cir. 1995); *Daniel v. Master Health Plan, Inc.*, 864 F. Supp. 1399, 1406 (S.D. Ga. 1994); *Schlett v. Avco Financial Servs., Inc.*, 950 F. Supp. 823, 833 (N.D. Ohio 1996).

Each approach has its deficiencies. If the existence of a "significant gap" between the continuation coverage and the pre-existing policy is viewed from an *ex post* standpoint, then it is literally impossible for a plan administrator to assess whether continuation coverage may be terminated at the time when the beneficiary makes his election—the only relevant time under the statute. On the other hand, if the existence of a "significant gap" is determined from an *ex ante* standpoint, then the inquiry requires the plan administrator to assess a host of facts—regarding the beneficiary's medical condition and the details of coverage under the new plan—that are likely to be unavailable at the time of election. In either event, the plan administrator must make widespread comparisons of each plan's coverage of numerous types of conditions and treatments, deductibles, copayments, and benefit ceilings. The need to make such a complex calculation, based on such indeterminate variables, would extraordinarily complicate

the task of the plan administrator. And, since qualified beneficiaries have a private right of action to enforce their rights to employee benefits, see 29 U.S.C. 1132(a)(1), adoption of the "significant gap" theory would be likely to spawn litigation aimed at resolution of coverage questions on a case-by-case basis.¹⁵

Not surprisingly, the courts have reached widely disparate results regarding what constitutes a significant gap. In *National Companies*, 929 F.2d at 1571, \$6,700 in personal liability did not amount to a significant gap, nor did \$7,500 in *Schlett*, 950 F. Supp. at 832-833, but in *McGee*, 17 F.3d at 1126, \$6,500 did. And no significant gap in coverage was found by the district court in the case of the Guillain-Barre patient whose medical bills exceeded the Teamsters' plan's \$250,000 annual cap by some \$35,000. *Lutheran Hosp.*, 845 F. Supp. at 1288, discussed at note 15, *supra*. This Court should be reluctant to thrust the various federal agencies responsible for enforcing the statute, as well as employers, insurers, courts, and

¹⁵ For example, the quandary presented in *Lutheran Hospital* was whether there was a "significant gap" for a patient with Guillain-Barre syndrome between continuation coverage that set no yearly limit but a \$1,000,000 lifetime cap on benefits and a pre-existing plan that had a \$250,000 yearly maximum but no lifetime limit. 51 F.3d at 1315. The majority in *Lutheran Hospital* eliminated the need for undertaking that inquiry by adopting the view that an employer may not base a termination of coverage on the existence of pre-existing coverage under another policy, regardless of the terms of that policy. As the court observed, "[w]e agree that a *post hoc* determination of personal liability is an inappropriate way to determine preexisting legal duties. But the fictional *ex ante* approach taken by the district court is no more appropriate and completely unworkable." *Ibid.*

qualified beneficiaries alike, into a vain quest for standards for resolving particular cases under this thorny—and irrelevant—construct.

As the Seventh Circuit observed in *Lutheran Hospital*, 51 F.3d at 1315, “[t]his whole morass can be avoided by honoring the language of the statute and the decision of the insured as to how much coverage is adequate for her own situation.” If the statute is construed as it is written to permit termination of coverage only if the beneficiary becomes covered under a new group health plan, the “significant gap” inquiry can be discarded. Under that interpretation, the beneficiary himself determines whether it is worthwhile to elect (and pay for) COBRA continuation coverage as well as—or instead of—the pre-existing coverage. Similarly, the beneficiary himself determines when COBRA coverage ends, by obtaining coverage under a new plan that—in accordance with the statutory standard—“does not contain any exclusion or limitation with respect to any pre-existing condition of [the] beneficiary.” 29 U.S.C. 1162(2)(D)(i). That result is consonant with the basic principle underlying the COBRA provisions: that it should be left to the beneficiary—who is in the best position to gauge his own health care needs and his own willingness to pay for coverage—to compare alternative plans and decide which provides adequate coverage at rates the beneficiary can afford.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General

LORETTA C. ARGRETT
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

JAMES A. FELDMAN
Assistant to the Solicitor General

GARY R. ALLEN
TERESA E. McLAUGHLIN
Attorneys

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APPENDIX

Title 29 of the United States Code provides in pertinent part:

§ 1161. Plans must provide continuation coverage to certain individuals

(a) In general

The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

(b) Exception for certain plans

Subsection (a) of this section shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year.

§ 1162. Continuation coverage

For purposes of section 1161 of this title the term "continuation coverage" means coverage under the plan which meets the following requirements:

(1) Type of benefit coverage

The coverage must consist of coverage which, as of the time the coverage is being provided, is

identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

(2) Period of coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(A) Maximum required period

(i) General rule for terminations and reduced hours

In the case of a qualifying event described in section 1163(2) of this title, except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

(ii) Special rule for multiple qualifying events

If a qualifying event (other than a qualifying event described in section 1163(6) of this title) occurs during the 18 months after the date of a qualifying event described in section 1163(2) of this title, the date which is 36 months after the date of the

qualifying event described in section 1163(2) of this title.

(iii) Special rule for certain bankruptcy proceedings

In the case of a qualifying event described in section 1163(6) of this title (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in section 1167(3)(C)(iii) of this title), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee.

(iv) General rule for other qualifying events

In the case of a qualifying event not described in section 1163(2) or 1163(6) of this title, the date which is 36 months after the date of the qualifying event.

(v) Medicare entitlement followed by qualifying event

In the case of a qualifying event described in section 1163(2) of this title that occurs less than 18 months after the date the covered employee became entitled to benefits under Title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.], the period of coverage for qualified beneficiaries other than the covered employee shall not terminate under this subparagraph before the close of the 36-month

period beginning on the date the covered employee became so entitled.

In the case of a qualified beneficiary who is determined, under Title II or XVI of the Social Security Act [42 U.S.C.A. § 401 et seq. or 1381 et seq.], to have been disabled at any time during the first 60 days of continuation coverage under this part, any reference in clause (i) or (ii) to 18 months is deemed a reference to 29 months (with respect to all qualified beneficiaries), but only if the qualified beneficiary has provided notice of such determination under section 1166(3) of this title before the end of such 18 months.

(B) End of plan

The date on which the employer ceases to provide any group health plan to any employee.

(C) Failure to pay premium

The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

(D) Group health plan coverage or medicare entitlement

The date on which the qualified beneficiary first becomes, after the date of the election—

(i) covered under any other group health plan (as an employee or otherwise) “which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary” (other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of Title 26, part 7 of this subtitle, or title XXVII of the Public Health Service Act [42 U.S.C.A. § 300gg et seq.]), or

(ii) in the case of a qualified beneficiary other than a qualified beneficiary described in section 1167(3)(C) of this title, entitled to benefits under title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.].

(E) Termination of extended coverage for disability

In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this part, the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act [42 U.S.C.A. § 401 et seq. or

1381 et seq.] that the qualified beneficiary is no longer disabled.

(3) Premium requirements

The plan may require payment of a premium for any period of continuation coverage, except that such premium—

(A) shall not exceed 102 percent of the applicable premium for such period, and

(B) may, at the election of the payor, be made in monthly installments.

In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to “102 percent” is deemed a reference to “150 percent” for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).

(4) No requirement of insurability

The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(5) Conversion option

In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

§ 1163. Qualifying event

For purposes of this part, the term “qualifying event” means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

- (1) The death of the covered employee.
- (2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.
- (3) The divorce or legal separation of the covered employee from the employee's spouse.
- (4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.].
- (5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.
- (6) A proceeding in a case under Title 11, commencing on or after July 1, 1986, with respect to

the employer from whose employment the covered employee retired at any time.

In the case of an event described in paragraph (6), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in section 1167(3)(C) of this title within one year before or after the date of commencement of the proceeding.

§ 1164. Applicable premium

For purposes of this part—

(1) In general

The term “applicable premium” means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

(2) Special rule for self-insured plans

To the extent that a plan is a self-insured plan—

(A) In general

Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such

period for similarly situated beneficiaries which—

(i) is determined on an actuarial basis, and

(ii) takes into account such factors as the Secretary may prescribe in regulations.

(B) Determination on basis of past cost

If an administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

(C) Subparagraph (B) not to apply where significant change

An administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding

determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

(3) Determination period

The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

§ 1165. Election

For purposes of this part—

(1) Election period

The term “election period” means the period which—

(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

(B) is of at least 60 days’ duration, and

(C) ends not earlier than 60 days after the later of—

(i) the date described in subparagraph (A), or

(ii) in the case of any qualified beneficiary who receives notice under section 1166(4)¹ of this title, the date of such notice.

(2) Effect of election on other beneficiaries

Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 1167(3) of this title shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

§ 1166. Notice requirements

(a) In general

In accordance with regulations prescribed by the Secretary—

(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,²

¹ So in original. Probably should be “1164(a)(4)”

² So in original. Probably should be “this part”.

(2) the employer of an employee under a plan must notify the administrator of a qualifying event described in paragraph (1), (2), (4), or (6) of section 1163 of this title within 30 days (or, in the case of a group health plan which is a multi-employer plan, such longer period of time as may be provided in the terms of the plan) of the date of the qualifying event,

(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 1163 of this title within 60 days after the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act [42 U.S.C.A. § 401 et seq. or 1381 et seq.], to have been disabled at any time during the first 60 days of continuation coverage under this part is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

(4) the administrator shall notify—

(A) in the case of a qualifying event described in paragraph (1), (2), (4), or (6) of section 1163 of this title, any qualified beneficiary with respect to such event, and

(B) in the case of a qualifying event described in paragraph (3) or (5) of section 1163 of this title where the covered employee notifies

the administrator under paragraph (3), any qualified beneficiary with respect to such event, of such beneficiary's rights under this subsection³

(b) Alternative means of compliance with requirements for notification of multiemployer plans by employers

The requirements of subsection (a)(2) of this section shall be considered satisfied in the case of a multiemployer plan in connection with a qualifying event described in paragraph (2) of section 1163 of this title if the plan provides that the determination of the occurrence of such qualifying event will be made by the plan administrator.

(c) Rules relating to notification of qualified beneficiaries by plan administrator

For purposes of subsection (a)(4) of this section, any notification shall be made within 14 days (or, in the case of a group health plan which is a multi-employer plan, such longer period of time as may be provided in the terms of the plan) of the date on which the administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

³ So in original. Probably should be "this part".

§ 1167. Definitions and special rules

For purposes of this part—

(1) Group health plan

The term “group health plan” means an employee welfare benefit plan providing medical care (as defined in section 213(d) of Title 26) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of Title 26).

(2) Covered employee

The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of Title 26).

(3) Qualified beneficiary

(A) In general

The term “qualified beneficiary” means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

- (i) as the spouse of the covered employee, or

- (ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this part.

(B) Special rule for terminations and reduced employment

In the case of a qualifying event described in section 1163(2) of this title, the term “qualified beneficiary” includes the covered employee.

(C) Special rule for retirees and widows

In the case of a qualifying event described in section 1163(6) of this title, the term “qualified beneficiary” includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

- (i) as the spouse of the covered employee,
- (ii) as the dependent child of the employee, or
- (iii) as the surviving spouse of the covered employee.

(4) Employer

Subsection (n) (relating to leased employees) and subsection (t) (relating to application of controlled group rules to certain employee benefits) of section 414 of Title 26 shall apply for purposes of this part in the same manner and to the same extent as such subsections apply for purposes of section 106 of such title. Any regulations prescribed by the Secretary pursuant to the preceding sentence shall be consistent and coextensive with any regulations prescribed for similar purposes by the Secretary of the Treasury (or such Secretary's delegate) under such subsections.

(5) Optional extension of required periods

A group health plan shall not be treated as failing to meet the requirements of this part solely because the plan provides both—

(A) that the period of extended coverage referred to in section 1162(2) of this title commences with the date of the loss of coverage, and

(B) that the applicable notice period provided under section 1166(a)(2) of this title commences with the date of the loss of coverage.